(22)

No. 90-97

IN THE

Supreme Court of the United States

OCTOBER TERM, 1990

AMERICAN HOSPITAL ASSOCIATION

v.

NATIONAL LABOR RELATIONS BOARD, *et al.*

On Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

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BRIEF FOR THE SOCIETY FOR HUMAN RESOURCE MANAGEMENT AS AMICUS CURIAE SUPPORTING PETITIONER

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CONSENT TO FILING

This *amicus curiae* brief is filed pursuant to Supreme Court Rule 37.2, with the written consent of all parties in interest. Letters of consent have been filed with the Clerk of this Court.

INTEREST OF THE AMICUS CURIAE

The Society for Human Resource Management ("SHRM" or the "Society") is the world's largest association of personnel and human resources professionals, representing over 46,000 individuals and entities in business, government and education. The primary goal of the Society and its members is to further effective personnel and human resource management. Accordingly, SHRM has a keen interest in the development and enforcement of the myriad laws and regulations governing every aspect of employment.

A substantial number of the Society's members either work in or have significant connections with the health

care industry. In turn, as the major professional human resources organization in the nation, SHRM is vitally concerned with the orderly evolution of laws governing labor-management relations in acute-care hospitals and other health care institutions. SHRM has long recognized its special responsibility to support and encourage compliance with the National Labor Relations Act ("NLRA" or the "Act"), 29 U.S.C. §§ 151-68 (1982). And in that regard, the Society believes that this case presents the Court with an excellent opportunity to strike a careful balance between the fundamentally compatible dual goals of section 9(b) of the Act—namely, providing the National Labor Relations Board ("NLRB" or the "Board") with the procedural flexibility to protect the organizational rights of health care workers, while simultaneously preserving the right of employers and other interested parties to make case-specific showings with respect to the appropriateness of proposed collective bargaining units. On that basis, SHRM urges this Court to reverse the judgment of the Court of Appeals.[1]

ISSUE PRESENTED

May the National Labor Relations Board promulgate and enforce *per se* unit determination rules in the health care industry, thereby foreclosing health care employers from presenting evidence "in each case" regarding the appropriateness of proposed collective bargaining units?

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[1] The Society has repeatedly indicated for the record its opposition to the "unit determination rules" that are at issue in this case. SHRM filed substantive comments with the NLRB during the rulemaking proceedings and urged the Board to continue to decide representation cases in the health care industry on an "adjudicated," case-by-case basis. In turn, through this *amicus* brief, the Society now renews its position that the Board cannot ignore the requirements of section 9(b) of the Act and the congressional "nonproliferation mandate" accompanying the Health Care Amendments Act of 1974 by promulgating and enforcing *per se* unit determination rules for application in cases involving acute-care hospitals.

SUMMARY OF ARGUMENT

1. By its terms, section 9(b) of the Act provides that the Board "*shall* decide *in each case* whether, in order to assure to employees the fullest freedom in exercising the rights guaranteed by this subchapter, the unit appropriate for the purposes of collective bargaining shall be the employer unit, craft unit, plant unit, or subdivision thereof." 29 U.S.C. § 159(b) (1982) (emphasis supplied). This plain and simple statutory mandate requires the NLRB to resolve disputes over the "appropriateness" of proposed collective bargaining units on an employer-specific, case-by-case basis. It broadly embodies, moreover, Congress' common-sense recognition that "[wide] variations in the forms of employee self-organization and the complexities of modern industrial organization make difficult the use of inflexible rules as the test of an appropriate unit." *NLRB v. Hearst Publications, Inc.*, 322 U.S. 111, 134 (1944).

2. More than sixteen years ago, Congress extended the NLRA's protections to the employees of private, nonprofit hospitals by adopting the Health Care Amendments Act of 1974 (the "1974 Amendments"), Pub. L. No. 93-360, 88 Stat. 395 (1974) (amending 29 U.S.C. §§ 151-68 (1973)). It did so, however, against the background of a broad legislative consensus "that the hospital industry was unique and that disruptions caused by organizational drives and related activities at a hospital were a far more serious concern than at an industrial plant given the grave nature of medical care and the fact that 'Hospital care is not storable.'" *NLRB v. St. Francis Hospital of Lynwood*, 601 F.2d 404, 411 (9th Cir. 1979) (quoting S. Rep. No. 766, 93d Cong., 2d Sess. 39 (1974) (individual views of Sen. Dominick), *reprinted in* 1974 U.S. Code Cong. & Admin. News 3946, 3953). Accordingly, the House and Senate committee reports accompanying the 1974 Amendments included identical language specifically directing the NLRB to *prevent* the proliferation of bargaining units in health care institutions. *See* S. Rep. No. 766, 93d Cong., 2d Sess. 5

(1974), *reprinted in* 1974 U.S. Code Cong. & Admin. News 3946, 3950; H.R. Rep. No. 1051, 93d Cong., 2d Sess. 6-7 (1974).

As the circuit courts have repeatedly held, "[b]ecause this legislative comment to nonproliferation is explicit in the legislative history leading to the repeal of the prior exemption [of nonprofit hospitals from the coverage of the NLRA], it is binding on the NLRB and must be implemented by it." *NLRB v. HMO International/California Medical Group Health Plan, Inc.*, 678 F.2d 806, 808 (9th Cir. 1982). Yet the express "nonproliferation mandate" is not the only significant feature of the legislative history of the 1974 Amendments. The Ninety-Third Congress had previously allowed two alternative proposals to die in committee. The first, S. 794, would simply have repealed the preexisting exemption outright; while the second, S. 2292, would have provided for a maximum of five "presumptively appropriate" bargaining units in the health care industry—namely, all professional employees, all technical employees, all clerical employees, all service and maintenance employees and all guards.

As demonstrated below, the only fair inference to be drawn from Congress' failure to enact either proposal—and its later adoption of compromise legislation—is that it considered *and then rejected* a procedural departure from the existing, statutorily mandated "case-by-case" approach to Board resolution of unit determination disputes. Thus, contrary to the Respondent's repeated assertions below, the legislative history of the 1974 Amendments and Congress' purported "rejection" of S. 2292 suggest that the statute's draftsmen meant for the Board to continue to decide representation cases on the basis of highly variable, case-specific records—i.e., consistent with the express terms of section 9(b) of the Act.

3. The NLRB's new health care bargaining unit determination rules, 54 Fed. Reg. 16,347-48 (1989) (hereinafter cited as "Final Rule") (codified at 29 C.F.R.

§ 103.30 (1990)), contravene both the "in each case" procedural requirement of section 9(b) *and* the "nonproliferation mandate" accompanying the 1974 Amendments. First, as the Board itself acknowledges, the new rules effectively foreclose any future case-specific adjudications of the "appropriateness" of proposed bargaining units. Indeed, they do so by specific design.[2] Second, the new rules inherently *encourage*, rather than prevent, the "proliferation" of bargaining units in the health care industry. Standing alone, the "nonproliferation mandate" appearing in the House and Senate committee reports forecloses the Board from establishing, either by rule *or* adjudication, definitive "presumptions" with respect to bargaining unit "appropriateness." *See, e.g., NLRB v. Mercy Hospital Association*, 606 F.2d 22, 27-28 (2d Cir. 1979), *cert. denied*, 445 U.S. 971 (1980). Yet as a threshold matter, the Board's unit determination rules obviously accomplish precisely this prohibited purpose. Equally important, the new rules by their very nature contemplate bargaining unit "proliferation." In no other identifiable "industry" has the Board been will-

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[2] *See, e.g.*, Second Notice of Proposed Rulemaking, 53 Fed. Reg. 33,933 (1988) (hereinafter cited as "NPR II") ("[T]he Board has made a judgment that, in this area of establishing appropriate units, '[d]etailed analyses of all the facts of the particular case are just not that enlightening.'") (quoting Subrin, *Conserving Energy at the Labor Board: The Case for Making Rules on Collective Bargaining Units*, 32 Lab. L.J. 105, 107 (1981)). The new rules include a "catchall" exception to their general applicability and provide that, "[w]here extraordinary circumstances exist, the Board shall determine appropriate units by adjudication." 29 C.F.R. § 103.30(b) (1990). The Board has made plain, however, that its "intent is to construe the extraordinary circumstances exception narrowly." NPR II, 53 Fed. Reg. at 33,932. For example, NPR II lists a number of circumstantial "variations" among acute-care hospitals that apparently will not, "alone or in combination, constitute[] 'extraordinary circumstance[s]' justifying an exception from the rule." *Id.* The Board has expressly indicated, moreover, that "*none* of the arguments raised in the course of the rulemaking procedure" will be sufficient, if asserted anew in future unit determination cases, to justify invocation of the "extraordinary circumstances" exception. *Id.* (emphasis supplied).

ing to certify as "appropriate" eight definitionally distinct bargaining units. It now seeks to do so as a matter of course—notwithstanding Congress' expressed concern that "[h]ealth-care institutions must *not* be permitted to go the route of other industries . . . in this regard." 120 Cong. Rec. 12,944-45 (May 2, 1974) (remarks of Sen. Taft) (emphasis supplied).

4. From the unique perspective of this *amicus*, however, the dispositive point is that the section 103.30 unit determination rules are broadly inconsistent with the spirit, as well as the letter, of the NLRA itself and the 1974 Amendments. As a practical matter, the Board's promulgation of rules that establish the same, *per se* bargaining unit structure at each general acute-care hospital in the nation seals shut the doors of the federal courts to health care employers seeking to question and appeal effectively NLRB bargaining unit determinations. Given the highly unstable, politicized environment in which the Board operates,[3] the right to appeal unit determinations has become an increasingly important check and balance on agency discretion.[4] The Board's new rules would dispense with individualized, case-by-case determinations of bargaining unit "appropriateness" in health care institutions, thereby foreclosing meaningful appellate review of individual unit determinations in one of the nation's largest industries. Thus, in the Society's view, the new approach eliminates the *only* meaningful check on agency discretion in this area and, in turn, al-

[3] The Board has been plagued by remarkable political instability since the adoption of the 1974 Amendments. Indeed, twenty-two different individuals—thirteen Republicans, seven Democrats and two independents—have served on the five-member Board in the last sixteen years. In the same period, six individuals have served as the Board's Chairman.

[4] As the Board itself has recognized, the appellate courts have become increasingly critical of the agency's failure to develop cogent decisional principles that pay heed to the congressional admonition against the "proliferation" of bargaining units in the health care industry. Notice of Proposed Rulemaking, 52 Fed. Reg. 25,142-43 (1987) (citing cases).

lows the Board to "hide" behind its own rules, routinely invoking them as the justification for arbitrary certifications of manifestly *inappropriate* bargaining units.

5. The legislative history of the 1974 Amendments makes plain that Congress struck a careful and delicate balance between its desire to protect the right of workers to organize and bargain collectively with their employers and a recognized need to protect against employment relations instability at the nation's health care institutions and corresponding escalations in the cost of treatment. The Board's new unit determination rules substantially disrupt that balance and, consequently, undermine the important policies embodied in the governing statute.

Collective bargaining can be an exceedingly expensive proposition. New contracts, for example, are typically the product of months of negotiations that consume the time, energy and financial resources of employers and labor unions alike. More importantly, "collective bargaining gone awry" is even more expensive. Particularly in the health care industry, the potential for strikes, work slowdowns and other labor disruptions clearly threatens direct interference with day-to-day patient care and a serious escalation of costs.

As the Board has repeatedly acknowledged, the Ninety-Third Congress was especially sensitive to the health care industry's unique vulnerability to labor disruptions and the ever-increasing costs of personnel administration. It was clearly this concern, moreover, that motivated Congress both to preserve the existing "case-by-case" approach to the administrative determination of unit "appropriateness" and to admonish the Board to avoid the "proliferation" of bargaining units in health care institutions. The draftsmen of the 1974 Amendments preserved section 9(b)'s requirement that the Board determine bargaining unit appropriateness "in each case" precisely because they feared that, given the diversity inherently characterizing the health care industry, any

other approach might result in arbitrary and costly certifications of manifestly *inappropriate* units.[5] Likewise, Congress expressly cautioned the Board to avoid the "proliferation" of bargaining units in the health care industry largely "because it feared frequent strikes that would close hospitals and increase[] the cost of medical care through wage 'leapfrogging' and 'whipsawing' if hospital employees were represented by many different unions." *Beth Israel Hospital & Geriatric Center v. NLRB*, 688 F.2d 697, 700 (10th Cir.) (*en banc*), *cert. dismissed*, 459 U.S. 1025 (1982). The Board's new rules flout those public policy concerns and, in turn, will ultimately accomplish precisely the opposite of what the draftsmen of the 1974 Amendments intended.

6. In SHRM's view, it also bears emphasis that the administrative proceedings that led to the adoption of the new rules were seriously flawed. As even the Court of Appeals recognized, the Board "overlook[ed] a great deal of relevant diversity" in the industry—diversity that renders impossible generalizations with respect to the "appropriateness" of particular bargaining units. *American Hospital Association v. NLRB*, 899 F.2d 651, 659 (7th Cir. 1990) (hereinafter cited as "*AHA II*"). Perhaps more importantly, however, the Board *did* give "controlling weight" to evidence of prior organizing patterns in the industry—an approach that the NLRA itself expressly forecloses.

Upon careful reading, the various notices of proposed rulemaking in this case strongly suggest that the Board settled upon the eight "presumptively appropriate" bar-

[5] *See, e.g.*, Bumpass, *Appropriate Bargaining Units in Health Care Institutions: An Analysis of Congressional Intent and Its Implementation by the National Labor Relations Board*, 20 B.C.L. Rev. 867, 921 (1979) (surveying legislative history of 1974 Amendments and concluding that, in Congress' view, "the Board [could] adequately consider traditional criteria [of bargaining unit appropriateness] and congressional intent only through case by case analyses").

gaining units enumerated in the final rule largely on the basis of the "history" of collective bargaining in health care institutions. *See, e.g.*, NPR II, 53 Fed. Reg. at 33,910-11. Section 9(c)(5) of the Act expressly provides, however, that "[i]n determining whether a unit is appropriate for the purposes specified in [section 9(b)] the extent to which the employees have organized shall *not* be controlling." 29 U.S.C. § 159(c)(5) (1982) (emphasis supplied). Thus, notwithstanding whether section 6 of the Act implicitly authorizes the Board to dispense with case-by-case determinations of bargaining unit "appropriateness," the present rules are plainly unenforceable as a matter of law.

For all of the foregoing reasons, this Court should reverse the judgment of the Court of Appeals and reinstate the District Court's permanent injunction against enforcement of the NLRB's health care bargaining unit determination rules.

ARGUMENT

I. THE BOARD'S NEW HEALTH CARE BARGAINING UNIT DETERMINATION RULES CONTRAVENE THE EXPRESS TERMS OF THE NLRA AND UNDERMINE THE INTENT OF THE DRAFTSMEN OF THE HEALTH CARE AMENDMENTS ACT OF 1974

1. Section 9(b) of the Act is not merely precatory. Instead, it provides that the NLRB "*shall* decide [the appropriate bargaining unit] *in each case*." 29 U.S.C. § 159(b) (1982). Thus, as this Court has repeatedly held, the Board must flexibly examine the facts of each individual case to determine whether the certification of a proposed bargaining unit would further the goals of the Act. *See, e.g., NLRB v. Action Automotive, Inc.*, 469 U.S. 490, 494 (1985). Indeed, the NLRB has no choice but to adjudicate representation cases on their individual merits, inasmuch as "[t]he issue as to what unit is appropriate for bargaining is one for which no absolute rule of law is laid down by statute, *and none should be*

by decision." *Packard Motor Car Co. v. NLRB*, 330 U.S. 485, 491 (1947) (emphasis supplied).

> Wide variations in the forms of employee self-organization and the complexities of modern industrial organization make difficult the use of inflexible rules as the test of an appropriate unit. Congress was informed of the need for flexibility in shaping the unit to the particular case and accordingly gave the Board wide discretion in the matter . . . . The flexibility which Congress thus permitted has characterized the Board's administration of the section and has led it to resort to a wide variety of factors in case-to-case determination of the appropriate unit.

Hearst Publications, *supra*, 322 U.S. at 134.

The Act does not, however, merely "facilitate" administrative flexibility in the determination of appropriate bargaining units. Instead, it affirmatively *requires* the Board to decide what unit is "appropriate" on an individualized, case-by-case basis. *E.g.*, *Memorial Hospital of Roxborough v. NLRB*, 545 F.2d 351, 360 (3d Cir. 1976) ("Congress has . . . *mandated* Board determination 'in each case' of 'the unit appropriate' for collective bargaining. Thus[,] the statute *requires* the Board to exercise its discretion as to an appropriate unit *in each and every case.*") (emphasis supplied).[6] In turn, and as the Board itself has recognized, "irrebutable presumption[s] of the appropriateness of . . . units in all cases, *without regard to particular circumstances*, should be disavowed. Such

[6] *See also Big Y Foods, Inc. v. NLRB*, 651 F.2d 40, 45-46 (1st Cir. 1981) ("The only pertinent limitation [on the Board's role as the arbiter of representation disputes] is the § 9(b) statutory direction to the NLRB to make a decision 'in each case' . . . . [T]hat statutory direction invalidates a conclusive presumption [with respect to bargaining unit appropriateness] *because it precludes the NLRB from making a determination based upon the unique circumstances of a particular group of employees.*") (citations omitted) (emphasis supplied); *Allegheny General Hospital v. NLRB*, 608 F.2d 965, 968 (3d Cir. 1979) (Section 9(b) "requires the Board to exercise its discretion as to an appropriate unit *in each and every case.*") (emphasis supplied) (quoting *Memorial Hospital v. NLRB*, 545 F.2d 351 (3d Cir. 1976)).

a *per se* approach to unit determinations is inconsistent with the Board's Section 9(b) responsibility to decide 'in each case' whether the requested unit is appropriate." *Newton-Wellesley Hospital*, 250 NLRB 409, 411 (1980).

2. The legislative history of the 1974 Amendments to the NLRA makes plain that Congress considered it imperative for the Board to adopt a "flexible" approach and determine bargaining unit "appropriateness" in the health care industry on a considered, case-by-case basis. Indeed, prior to its recent adoption of *per se* unit determination rules, the Board itself had repeatedly acknowledged its special obligation to resolve representation disputes involving health care institutions on the basis of careful, individualized analyses of *case-specific* circumstances. *See, e.g., St. Francis Hospital*, 271 NLRB 948, 951 n.17 (1984) (hereinafter cited as "*St. Francis II*") (adopting "disparity of interests" test that "establishes neither a minimum nor maximum number of appropriate bargaining units [in the health care industry], but rather permits the determination to be made *on the facts of the particular facility involved*" and holding that "this approach comports with Congress' intent that the Board . . . deal[] with unit determinations *on a case-by-case basis*") (emphasis supplied).[7] The dispositive point, however, is that the Board is *not* at liberty to reinterpret the governing statute and dispense with case-by-case consideration of representation questions. The draftsmen of the 1974 Amendments repeatedly emphasized the par-

[7] As the District Court held, the inconsistency between this prior administrative interpretation of section 9(b) and the Board's more recent insistence that the Act empowers it to dispense with "in each case" adjudications of bargaining unit appropriateness affirmatively undermines the agency's current legal position. "When, as here, an administrative agency vacillates in its interpretation of an authorizing statute, its interpretation is entitled to little deference." *American Hospital Association v. NLRB*, 718 F. Supp. 704, 711 n.12 (N.D. Ill. 1989) (citing *NLRB v. United Food & Commercial Workers Union*, 484 U.S. 112, 124 n.20 (1987), and *County of Washington v. Gunther*, 452 U.S. 161, 177-78 (1981)).

ticular importance of administrative "flexibility" in cases involving health care institutions and made a conscious, independent decision to *preserve* section 9(b)'s requirement that the Board determine the "appropriateness" of proposed bargaining units "in each case."[8] In turn, and as several circuit courts have held, the Board is necessarily *precluded* from relying upon irrebutable decisional or regulatory "presumptions" with respect to the propriety of proposed bargaining units in the health care industry.

A brief survey of various events preceding Congress' enactment of the 1974 Amendments illustrates the point well. Congress first considered the possibility of extending the coverage of the NLRA to the employees of nonprofit hospitals in 1972, when Congressmen John Ashbrook and Robert Thompson introduced a bill, H.R. 11357, that would have repealed outright the preexisting exclusion of such institutions from the definition of "employers" set forth in section 2(2) of the Act. *See Legislative History of the Coverage of Nonprofit Hospitals Under the National Labor Relations Act, 1974*, 93d Cong., 2d Sess. 105-06, 270 & 290 (1974) (hereinafter cited as "*Leg. Hist.*"). The House Education and Labor Committee reported the bill favorably to the full House, which approved H.R. 11357 on August 7, 1972. *Id.* at 105. The bill ultimately died in the Senate, however, after several legislators expressed concern that "provisions should be included which would accommodate the special characteristics of the industry." Bumpass, *supra* note 5, at 885 n.105.

The following year, shortly after the first session of the Ninety-Third Congress convened, Congressmen Ashbrook and Thompson introduced a second bill, H.R. 1236,

[8] *See, e.g., St. Francis Hospital of Lynwood*, 601 F.2d at 415-16 (concluding that, with respect to proposed bargaining units in health care institutions, Congress "demand[ed] individual examination by the Board, or its delegate, of the circumstances of each particular case").

calling for outright repeal of the nonprofit hospitals exemption. *Leg. Hist.* at 106, 270 & 465. Meanwhile, Senators Alan Cranston and Jacob Javits introduced an identical proposal, S. 794, in the Senate. *Id.* at 106. In response, Senator Robert Taft introduced an alternative bill, S. 2292, that would have repealed the exemption, but also would have provided for a maximum of four "presumptively appropriate" bargaining units in health care institutions. *Id.* at 106-11 & 457-58.

Senator Taft's staff coordinated the extensive negotiations that ensued among sponsors of the alternative proposals, health care industry lobbyists and representatives of the labor movement. *See* Bumpass, *supra* note 5, at 883. The compromise legislation that emerged, S. 3203, did *not* set forth any "presumptions" with respect to the appropriateness of particular collective bargaining units. The proponents of outright repeal of the nonprofit hospitals exemption ultimately agreed, however, that Congress should specifically admonish the Board to "prevent[] proliferation of bargaining units in the health care industry." S. Rep. No. 766, 93d Cong., 2d Sess. 5 (1974), *reprinted* in 1974 U.S. Code Cong. & Admin. News 3946, 3950; H.R. Rep. No. 1051, 93d Cong., 2d Sess. 6-7 (1974).

There is but one fair inference to be drawn from this sequence of events. S. 3203, the bill that the Ninety-Third Congress ultimately adopted, was a substantive compromise between those who favored express limitations on the number of "presumptively appropriate" bargaining units in the health care industry and others who favored extension of the Act's protections to the empioyees of nonprofit hospitals without any accompanying special protections for health care providers and their patients. Stated alternatively, Congress decided to extend the Act's coverage to nonprofit hospitals, but only with specific safeguards, including an explicit directive that the Board avoid unit proliferation. Congress made a conscious determination, moreover, that it could best protect against escalating costs in and possible disruptions of

the nation's health care delivery system by *preserving* section 9(b)'s "in each case" procedural requirement.[9]

The Board's promulgation of *per se* unit determination rules is clearly inconsistent, therefore, with the Ninety-Third Congress' vision of precisely how the NLRB would resolve representation disputes in the health care industry. Indeed, as Member Johansen pointedly indicated in his dissent from the Second Notice of Proposed Rulemaking, the Board has simply ignored the requirements of section 9(b) and the import of the circumstances surrounding the enactment of the 1974 Amendments.

> I do not read [section 9(b)] as permissive. It is mandatory. The Board cannot satisfactorily fulfill its statutory obligation by relegating its specialized decisional function in this area to rulemaking procedures. That is not to suggest that I disapprove of rulemaking per se. On the contrary, I agree that rulemaking is desirable, and even a necessary part of the Board's function, in some areas. This is not one of those areas. I believe it is important to note that Congress did *not* amend Section 9 when it enacted the Healthcare amendments in 1974. Had

[9] In the most exhaustive survey to date of the legislative history of the 1974 Amendments, T. Merritt Bumpass characterizes S. 3203 as a "compromise approach" to the "application of traditional bargaining unit criteria in the health care industry," Bumpass, *supra* note 5, at 886, and concludes that Congress imposed significant limitations on the Board's authority to establish irrebutable "presumptions" with respect to bargaining unit "appropriateness."

> The existence of . . . general rules affords employees, labor organizations, and health care institutions the predictability needed in the creation of bargaining units and promotes the efficiency of administrative and judicial processes. *However, when parties dispute the propriety of proposed bargaining units, the Board can adequately consider traditional criteria and congressional intent only through case by case analyses. Only when the Board examines the personnel, organizational structures, and operations of the institution in which a unit is sought can it give due consideration to the congressional mandate against the proliferation of bargaining units.*

Id. at 921 (emphasis supplied).

> Congress intended that the Board abandon the decisional approach and utilize a wholly new procedure for determining appropriate units in the healthcare industry, Congress would have told us so explicitly. It did not. Nor did it even implicitly suggest such action.

NPR II, 53 Fed. Reg. at 33,935 (Member Johansen, dissenting) (emphasis in original).

As it must, the Board concedes that its new unit determination rules effectively foreclose future case-specific determinations of bargaining unit appropriateness. Henceforth, absent "extraordinary circumstances," the Board will treat the eight narrow collective bargaining units enumerated in the rules as "the *only* appropriate units" in the health care industry. 29 C.F.R. § 103.30 (1990) (emphasis supplied).[10] The new rules are so inherently restrictive, therefore, that they cannot be considered mere "guideposts" for future, case-by-case determinations of bargaining unit "appropriateness." To the contrary, because the Board purports to have "carefully considered" Congress' nonproliferation mandate in the course of its rulemaking proceedings, *see, e.g.*, Final Rule, 54 Fed. Reg. at 16,337, health care providers will be entirely precluded in future cases from citing or relying upon the legislative history of the 1974 Amendments and its special implications in case-specific circumstances. Indeed, the Board clearly expects its unit determination rules to *themselves* "decide" future cases. It is precisely this feature of the Board's new approach, however, that renders the rules unenforceable. Section 9(b) *mandates* that the Board determine an appropriate unit "in each case." As the legislative history of the 1974 Amendments makes plain, moreover, Congress considered this requirement nowhere more important than in cases involving the health care industry. Notwithstanding whether the Board's procedural approach might be "administratively convenient," therefore,

[10] *See* note 2, *supra*, and accompanying text.

its unit determination rules are unenforceable as a matter of law.[11]

3. As indicated, Congress also specifically directed the Board to "prevent[] proliferation of bargaining units in the health care industry." S. Rep. No. 766, 93d Cong., 2d Sess. 5 (1974), *reprinted in* 1974 U.S. Code Cong. & Admin. News 3946, 3950; H.R. Rep. No. 1051, 93d Cong., 2d Sess. 6-7 (1974). The agency itself has repeatedly acknowledged that this nonproliferation admonition constitutes a binding congressional "directive," *St. Francis II*, 271 NLRB at 951, and that the Board's "consideration of the issues related to the composition of bargaining units in the health care industry must necessarily take place against the background of avoidance of undue proliferation." *The Jewish Hospital Association of Cincinnati*, 223 NLRB 614, 616 (1976). *See also* NPR II, 53 Fed. Reg. at 33,904-05 & 33,933 (congressional admonition against unit proliferation is mandatory, rather than permissive). Even more significantly, all but one of the circuit courts to consider the question have so held.[12]

[11] To so hold, this Court need only look to familiar canons of administrative law. "[I]f [agency] action is based upon a determination of law as to which the reviewing authority of the courts . . . come[s] into play, an order may not stand if the agency has *misconceived* the law." *SEC v. Chenery Corp.*, 318 U.S. 80, 94 (1943) (emphasis supplied). Here, the Board has clearly "misconceived" the import of section 9(b)'s "in each case" requirement. Accordingly, its unit determination rules cannot be sustained. *Cf. Prill v. NLRB*, 755 F.2d 941, 947 (D.C. Cir.) (reviewing court must refuse to sustain unit determination "where it is based not on the agency's own judgment but on an erroneous view of the law"), *cert. denied*, 474 U.S. 948 (1985).

[12] *See, e.g., NLRB v. Walker County Medical Center*, 722 F.2d 1535, 1538-39 (11th Cir. 1984); *Trustees of Masonic Hall & Asylum Fund v. NLRB*, 699 F.2d 626, 632-33 (2d Cir. 1983); *NLRB v. Frederick Memorial Hospital*, 691 F.2d 191, 193-94 (4th Cir. 1982); *HMO International*, 678 F.2d at 808; *Presbyterian/St. Luke's Medical Center v. NLRB*, 653 F.2d 450, 457 (10th Cir. 1981); *Mary Thompson Hospital v. NLRB*, 621 F.2d 858, 864 (7th Cir. 1980); *Allegheny General Hospital*, 608 F.2d at 968-69; *Bay Medical Center v. NLRB*, 588 F.2d 1174, 1177-78 (6th Cir. 1978), *cert. denied*, 444 U.S. 827 (1979). *But see International Brotherhood of Elec. Workers, Local 474 v. NLRB*, 814 F.2d 697, 712-14 (D.C. Cir. 1987).

In the present case, the Court of Appeals lent credence to the majority interpretation of the "admonition" appearing in the 1974 committee reports and treated the nonproliferation mandate as "equivalent to pre-enactment legislative history, rather than as a gratuitous comment unrelated to legislative action." *AHA II*, 899 F.2d at 658.[13] The Respondent does not dispute this finding and, for that matter, appears to concede that the only relevant question for this Court is whether "the Board's consideration of the issue of proliferation has been sufficient." Brief for the National Labor Relations Board on Petition for a Writ of Certiorari at 14. Having framed the dispositive issue in this way, however, the Board cannot hope to prevail. The section 103.30 unit determination rules inherently *encourage* unit proliferation, both by dispensing with case-by-case determinations of bargaining unit "appropriateness" and by establishing a greater number

[13] In that regard, the lower court's discussion of the significance of the committee reports cogently illustrates precisely why the D.C. Circuit erred in concluding that the Board is effectively free to ignore the congressional admonition against the proliferation of bargaining units in the health care industry. *See International Brotherhood of Elec. Workers*, 814 F.2d at 712.

> The admonition . . . accompanied the enactment of substantial amendments. The particular statutory provision to which the admonition was addressed was not amended, but the effect of the amendments was to apply that provision for the first time to the nonproprietary hospital industry. Section 9(b) directs the Board to determine the "appropriate" unit, and what is appropriate may differ from one industry to another—may therefore "mean" something different in one industry from what it means in another. So in changing the domain of application of section 9(b), the 1974 amendments may have changed its meaning without changing its words. The admonition can therefore be regarded as a commentary on the meaning of the 1974 amendments and hence as equivalent to pre-enactment legislative history . . . .

AHA II, 899 F.2d at 658.

of discrete units than the Board has been willing to certify in almost any other identifiable "industry." In turn, this Court must hold that the rules are unenforceable as a matter of law.

The "nonproliferation mandate" appearing in the 1974 committee reports affirmatively precludes the Board from establishing, either by rule or adjudication, definitive "presumptions" with respect to bargaining unit "appropriateness." In *St. Francis Hospital of Lynwood*, for example, the Ninth Circuit explained as follows its refusal to approve a Board "presumption" in favor of the appropriateness of bargaining units comprised solely of registered nurses.

> The key question raised herein is whether the *per se* policy established in the Board's *Mercy* decision [14] (that a bargaining unit of registered nurses is irrebuttably appropriate when sought in a non-profit hospital) is consistent with the Congressional directive that the Board give "due consideration" to preventing undue proliferation of bargaining units in the health care industry and Congress's expressed approval of the trend towards broader units in this area. We conclude that it clearly is not.
>
> From the legislative history of the 1974 Amendments . . . , it is apparent that Congress sought to encourage the Board to find broader bargaining units in the health care industry rather than narrower ones. The [] *Mercy* precedent contravenes that congressional admonition by establishing an irrebutable presumption in favor of certain units . . . .
>
> Moreover, the *per se* policy as applied by the Board herein prevents the [employer] from presenting any evidence to demonstrate that the circumstances in its case . . . might justify an all-professional unit. *By setting up a policy which is automatically applied and irrebutable without any examination of the particular situation involved, the Board fails to give "due consideration" to the congressional directive in that case.*

[14] *Mercy Hospitals of Sacramento, Inc.*, 217 NLRB 765 (1975).

St. Francis Hospital of Lynwood, 601 F.2d at 414 (footnote omitted) (emphasis supplied). The congressional admonition necessarily requires, in other words, that the Board conduct "independent evaluation[s]" of bargaining unit appropriateness "in [each] particular hospital." *Mercy Hospital Association*, 606 F.2d at 27-28.

In that regard, the Board's new unit determination rules obviously undermine congressional intent. Indeed, the only difference between the present case and *St. Francis Hospital of Lynwood* is that there are now *eight* irrebutable "presumptions" with respect to bargaining unit appropriateness at issue. The Board nevertheless maintains that its thirteen years of "experience" in the field justifies the establishment of such presumptions, given that "what some have termed 'sensitive, case-by-case adjudication' " does not "appear" to have served "any useful purpose." NPR II, 53 Fed. Reg. at 33,901. It simply is not within the *Board*'s purview, however, to make that determination.

Perhaps more important than the legal and procedural impropriety of the Board's new approach, however, is its indefensible practical effect. The new rules envision as many as eight separate bargaining units at an acute-care hospital, regardless of its size, its organizational structure or the extent to which its employees "cross-train" and interact as a necessary function of their day-to-day responsibilities. In contrast, the Board has typically been willing to certify as "appropriate" only *four* broad units—all professional employees, all production and maintenance employees, all technical employees and all clerical employees—in other industries. Bumpass, *supra* note 5, at 903. The generally recognized exception is the construction industry, wherein the Board has consistently certified separate bargaining units for "virtually *every* professional interest or job classification." *Mercy Hospital Association*, 606 F.2d at 27 (emphasis in original). As the draftsmen of the 1974 Amendments made plain, however, Congress' admonition against "unwarranted unit frag-

mentation" was motivated by a concern that "[h]ealth-care institutions . . . *not* be permitted to go the route of other industries, *particularly* the construction trades, in this regard." 120 Cong. Rec. 12,944-45 (May 2, 1974) (remarks of Sen. Taft) (emphasis supplied).[15] Indeed, Congress admonished the Board to avoid bargaining unit "proliferation" precisely because it wished "to stress the necessity [that] the Board . . . *reduce* and *limit* the number of bargaining units in a health care institution" and, consequently, find appropriate only the *broadest* possible units. 120 Cong. Rec. 12,944 (May 2, 1974) (remarks of Sen. Taft) (emphasis supplied). Thus, by providing for a far *greater* number of bargaining units in health care institutions than in virtually any other industry, the Board's new rules directly undermine congressional intent. Accordingly, this Court should hold that the section 103.30 unit determination rules are unenforceable as a matter of law.

II. THE PROMULGATION AND ENFORCEMENT OF *PER SE* UNIT DETERMINATION RULES IN THE HEALTH CARE INDUSTRY UNDERMINES THE IMPORTANT PUBLIC POLICIES EMBODIED IN THE 1974 AMENDMENTS TO THE NLRA

The courts below quite properly focused on the question of whether the Board's new unit determination rules are consistent with the precise terms of the NLRA itself and the legislative history of the 1974 Amendments. And in that regard, the Society submits that this is a clear

[15] The Board reads this expression of congressional intent narrowly, arguing that legislators were concerned *only* with "the possibility of scores of units" that had plagued the construction trades. NPR II, 53 Fed. Reg. at 33,933. *See also Allegheny General Hospital*, 239 NLRB 872, 875 (1978), *enforcement denied*, 608 F.2d 965 (3d Cir. 1979). Congress clearly intended, however, "that health care institutions be spared *not only* the 'egregious' unit proliferation of the construction industry, but also the less extreme unit fragmentation caused by applying traditional unit criteria." Bumpass, *supra* note 5, at 893 n.166 (emphasis supplied) (discussing *Mercy Hospital Association*, 606 F.2d at 27).

case. From the perspective of this *amicus*, however, the fatal flaw in the Board's new approach is that it flouts the important *policies* that the Ninty-Third Congress sought to protect. The 1974 Amendments to the NLRA strike an exceedingly delicate balance between competing legislative goals—namely, protecting the organizational rights of health care workers, while at the same time guarding against employment relations instability and corresponding cost escalations in the health care industry. The new rules upset that balance and, accordingly, undermine the entire framework of the governing statute.

The Ninety-Third Congress clearly recognized "that the hospital industry was unique and that disruptions caused by organizational drives and related activities at a hospital were a far more serious concern than at an industrial plant given the grave nature of medical care and the fact that 'Hospital care is not storable.'" *St. Francis Hospital of Lynwood*, 601 F.2d at 411 (quoting S. Rep. No. 766, 93d Cong., 2d Sess. 39 (1974) (individual views of Sen. Dominick), *reprinted in* 1974 U.S. Code Cong. & Admin. News 3946, 3953). Indeed, the legislative history of the 1974 Amendments is pervaded with expressions of concern "that egregious unit proliferation . . . could impede effective health care delivery." *Presbyterian/St. Luke's*, 653 F.2d at 457. Accordingly, for reasons aptly summarized by Senator Taft, Congress sought both to preserve administrative "flexibility" in the determination of bargaining unit appropriateness and to *prevent* "unwarranted unit fragmentation" in health care institutions.

> [T]he Board should be permitted some flexibility in unit determination cases. I cannot stress enough, however, the importance of great caution being exercised by the Board in reviewing unit cases in this area. Unwarranted unit fragmentation leading to jurisdictional disputes and work stoppages must be prevented.
>
> The administrative problems from a practical operation viewpoint and labor-relation[s] viewpoint must

> be considered by the Board on this issue. Health-care institutions must not be permitted to go the route of other industries, particularly the construction trades, in this regard.
>
> In analyzing the issue of bargaining units, the Board should also consider the issue of the cost of medical care. Undue unit proliferation must not be permitted to create wage "leapfrogging" and "whipsawing." The cost of medical care in this country has already skyrocketed, and costs must be maintained at a reasonable level to permit adequate health care for Americans from all economic sectors.

120 Cong. Rec. 12,944-45 (May 2, 1974) (remarks of Sen. Taft).

Congress' concerns in this regard were eminently realistic. Indeed, it stretches credulity for the Board to have concluded that the health care industry is *not* particularly vulnerable to labor relations instability flowing from bargaining unit "proliferation," or that "unit fragmentation" does not threaten serious escalations of the cost of medical care. *See, e.g.*, Final Rule, 54 Fed. Reg. at 16,339; NPR II, 53 Fed. Reg. at 33,903. Putting aside that the Board clearly was not at liberty to substitute its judgment for Congress' prior conclusion that a "multiplicity" of bargaining units would in fact disrupt the nation's health care delivery system, the agency's conclusions simply defy common sense.

> For a variety of reasons, the pattern of bargaining units which is established . . . is of considerable significance to health care institutions, their employees . . . and to the general public. *The numbers and types of units established can reasonably be expected to have an impact on the incidence of labor disputes in health care institutions, and thus upon the interruption of the delivery of services by such institutions, the costs of health care services [and] the administrative burden of managing health care institutions* . . . .

Bumpass, *supra* note 5, at 868 n.8 (emphasis supplied). As the Board itself recognizes, the direct costs of collective bargaining are exceedingly high. Hospitals typically expend between fifteen and fifty thousand dollars to negotiate a single collective bargaining agreement. Final Rule, 54 Fed. Reg. at 16,339. There are, moreover, significant costs associated with the day-to-day administration of such agreements, which typically require employers to establish complex (hence costly) mechanisms for the adjustment of employee grievances and progressive appeals of employee discipline. *Id.*

By far the most significant cost of collective bargaining, however, is the disruption that necessarily obtains when intractable labor-management disputes develop. If such disputes result in strikes, walkouts or work slowdowns, the consequences can be devastating. The direct cost to a health care employer of a single strike, including legal fees, replacement workers' wages and lost revenues, can in some circumstances exceed one *million* dollars. *Id.* Of course, the *indirect* costs are inestimable. They are typically borne, moreover, by the "consumers" of health care services—i.e., the patients whose interests are directly compromised by disruptions in hospital operations.

Congress likely recognized that, at some level, these "direct costs" represent the price that simply must be paid if health care workers are to enjoy the benefits of collective bargaining. The draftsmen of the 1974 Amendments sought to *minimize* such costs, however, to the fullest extent possible. Health care institutions' expenditures for contract negotiations, personnel systems administration and strike remediation are obviously a direct function of the number of bargaining units certified as "appropriate" at the facility, rather than the gross number of employees working under union contract. It is clearly safe to assume, for example, that a hospital will spend twice as much to complete a cycle of negotiations with eight collective bargaining units than it would in similar negotiations with only four units. To the extent that the workforce is unnecessarily frag-

mented, therefore, the costs of collective bargaining are likely to be unnecessarily high.

Costs are likely to escalate even further to the extent that employees must bargain with manifestly "inappropriate" bargaining units. Indeed, as the Board itself recognized only five years before it initiated rulemaking proceedings, the health care industry is particularly susceptible to the erroneous certification of "misconstituted" collective bargaining units. As a practical matter, "[t]he diverse nature of today's health care industry —including nursing homes, small hospitals, large medical centers, blood banks, outpatient clinics, etc.—precludes any generalization as to the appropriateness of any particular bargaining unit." *St. Francis II*, 271 NLRB at 953 n.39.

By consciously electing to preserve section 9(b)'s requirement that the Board determine an appropriate bargaining unit "in each case," Congress clearly sought to minimize the unnecessary costs associated with the certification of manifestly "inappropriate" units. Similarly, by specifically admonishing the Board to prevent the "proliferation" of bargaining units in the health care industry, the draftsmen of the 1974 Amendments sought to avoid the costly "disruptions" that necessarily obtain as a result of unit fragmentation. Unfortunately, the Board's new rules directly undermine *both* legislative goals. Accordingly, they are unenforceable as a matter of law.[16]

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[16] The Board's cursory answer to these criticisms, which various commentators repeatedly voiced in connection with the rulemaking proceedings, is that "[t]here is little if any evidence that multiple units in the health care industry have resulted in any of the problems perceived to arise from proliferation." NPR II, 53 Fed. Reg. at 33,908. This perfunctory assertion badly misses the mark, however, given that bargaining unit "proliferation" has thus far been *avoided* in the health care industry. As indicated, the circuit courts have insisted upon strict adherence to the "nonproliferation mandate" and required the Board to decide representation cases on their individual merits, thereby "policing" any administrative tendency to permit unwarranted unit fragmentaton. The Board's new unit determination rules would supplant the existing protections offered by this appellate review system, however, with a series of improper, irrebutable "presumptions" that will necessarily lead to previously unexperienced unit proliferation.

III. THE BOARD'S HEAVY RELIANCE ON THE "HISTORY OF COLLECTIVE BARGAINING" IN THE HEALTH CARE INDUSTRY VIOLATES THE EXPRESS TERMS OF SECTION 9(c)(5) OF THE ACT AND RENDERS THE SECTION 103.30 UNIT DETERMINATION RULES VOID AND UNENFORCEABLE

Section 9(c)(5) of the Act, 29 U.S.C. § 159(c)(5) (1982), provides that "[i]n determining whether a unit is appropriate for the purposes specified in [section 9(b) of the Act,] the extent to which the employees have organized shall not be controlling." On its face, this provision clearly does not "prohibit the Board from *considering* the extent of organization as one factor, though not the controlling factor, in its unit determination." *NLRB v. Metropolitan Life Ins. Co.*, 380 U.S. 438, 442 (1965) (emphasis supplied). The Board cannot "evade" section 9(c)(5), however, "by purporting to base its decision on other factors when in truth it has been controlled by the extent of employee organization." *NLRB v. Western & Southern Life Ins. Co.*, 391 F.2d 119, 122 (3d Cir. 1968) (quoting *NLRB v. Sun Drug Co.*, 359 F.2d 408, 412 (3d Cir. 1966)). Courts must refuse to enforce the Board's unit determination orders, therefore, where the record "justifi[es an] inference . . . that the extent of organization may have controlled the decision." *Sun Drug*, 359 F.2d at 412.

The record of the administrative proceedings that led to promulgation of the section 103.30 unit determination rules not only justifies an "inference" that prior organizing patterns "may" have controlled the Board's decision, but affirmatively compels the conclusion that the Board placed unwarranted (and statutorily foreclosed) emphasis

on the "history" of collective bargaining in the health care industry. First, as the American Hospital Association noted in its original petition for a writ of certiorari in this case, "the rule itself provides nothing new. [It] establishes eight bargaining units that are quite similar to the units the Board initially designated as appropriate in the years following enactment of the [1974] Amendments . . . ." Petition for a Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit at 23 (citing cases).[17] Indeed, only eight years ago, the Board surveyed its prior decisions and abortively attempted to establish eight "presumptively" appropriate bargaining units in the health care industry that were definitionally quite similar to those now enumerated in its unit determination rules. *St. Francis Hospital*, 265 NLRB 1025 (1982) (only "potentially appropriate" bargaining units in the health care industry are those comprised of physicians, registered nurses, other professional employees, technical employees, business office clerical employees, service and maintenance employees, skilled maintenance employees and guards). The necessary suggestion is, therefore, that the Board settled upon the eight definitionally distinct bargaining units enumerated in the new rules largely on the basis of the *preexisting* pattern of organization in acute-care hospitals.

A careful reading of the Board's successive rulemaking notices confirms that the agency selected the eight bargaining units defined in the rules in lieu of the various possible alternatives precisely because health care workers had previously organized along similar lines. The Board ultimately justified its refusal to define "broader"

[17] *See also* Bumpass, *supra* note 5, at 902 (surveying cases decided in the five years immediately subsequent to Congress' enactment of the 1974 Amendments and concluding that the Board had settled upon the "appropriate[ness of nine] separate bargaining units" comprised of registered nurses, physicians, residual professional employees, technical employes, service and maintenance employees, maintenance department or powerhouse employees, business office clericals, chauffeur-drivers and guards).

units than those set forth in the final rules, for example, on the ground that "[h]istorically, health care workers [have] organize[d] and engage[d] in initial bargaining in occupationally homogeneous units." NPR II, 53 Fed. Reg. at 33,910. Similarly, NPR II's lengthy discussion of the alleged "appropriateness" of the eight separate bargaining units ultimately chosen by the Board includes repeated representations that the "history" of collective bargaining in the industry ultimately justifies "presumptions" in favor of the propriety of such units. *See, e.g., id.* at 33,913-14 (registered nurses), 33,919-20 (technical employees), 33,921 (skilled maintenance employees) & 33,925 (business office clericals). Indeed, all three rulemaking notices are pervaded with "justifying" citations to *previous* Board decisions wherein the agency had certified as "appropriate" units similar to those enumerated in the final rules. *See, e.g.*, Notice of Proposed Rulemaking, 52 Fed. Reg. 25,147 (justifying proposal to deem units of "technical" employees presumptively appropriate on grounds that "we have consistently approved separate units of health care technical employees and excluded technicals from units of other nonprofessional employees") (citing *Southern Maryland Hospital*, 274 NLRB 1470 (1985); *Newington Children's Hospital*, 217 NLRB 793 (1975); and *Barnert Memorial Hospital Center*, 217 NLRB 775 (1975)).

Throughout these protracted discussions of the "history" of collective bargaining in the health care industry, moreover, the Board gives the distinct appearance of having acceded to the parochial and political desires of labor organizations. For example, the Board insists that separate units of registered nurses are "appropriate" because, according to the American Nurses Association, "RNs have for many years exhibited a strong desire for separate representation." NPR II, 53 Fed. Reg. at 33,913. Similarly, the Board justifies its determination that separate units of technical employees are *per se* "appropriate" partly on the basis of a bald statement that, "[a]t the [rulemaking] hearings, no union

organizer who was asked could recall any situation in which technical employees sought to [be] include[d in the same unit with] business office clericals or unskilled service workers, or vice versa." *Id.* at 33,920.

By far the most persuasive evidence that the Board considered the "history" of collective bargaining in the health care industry "controlling," however, is the suggestion in NPR II that rulemaking is *ultimately* justified by the "consistency" between the results reached in prior unit determination cases.

> [I]n numerous cases it had proven necessary to engage in lengthy, costly litigation over the appropriate bargaining unit or units. In retrospect, it appeared to the Board that there had been relative uniformity of workforce configurations and job classifications from facility to facility, *and even under adjudication the various Board members had reached virtually identical results from case to case.* Hence, it did not appear that what some have termed "sensitive, case-by-case adjudication" was serving any useful purpose.

NPR II, 53 Fed. Reg. at 33,901 (emphasis supplied).[18] The only fair inference to be drawn from this sweeping

[18] Indeed, the Board referred repeatedly to the presence of "recurring patterns" in its prior unit determination cases.

> Our adjudicatory decisions as to appropriate units in the health care industry . . . have been remarkably uniform in results, varying only when the Board changed doctrinal formulations, e.g., from "community" to "disparity" of interests . . . . Thus, for example, from 1975 to 1984, despite lengthy adjudicatory proceedings[,] the Board found RN units appropriate in 24 out of 25 published cases; technical units appropriate in 18 out of 18 cases; business office clerical units appropriate in 8 out 8 cases; etc. . . . Continuing to determine appropriate units in this way seems unproductive, especially considering the lack of universal judicial approval of any single doctrinal approach.

NPR II, 53 Fed. Reg. at 33,903 (footnote omitted). Similar statements pervade the administrative record in this case. In turn, the Board simply cannot deny that it gave "controlling weight" to the "history" of collective bargaining in the health care industry.

statement is that the Board has embodied in its new rules broad "presumptions" that do little more than "codify" certain *prior* unit determinations—hence reflect the agency's intention to reach future such determinations *solely* on the basis of "prior organizing patterns." Thus, while the Board paid lip service to the relevance of various other indicia of bargaining unit appropriateness, it clearly treated as "controlling" the thirteen-year "history" of collective bargaining in the industry. *Cf. Western & Southern Life*, 391 F.2d at 122; *Sun Drug*, 359 F.2d at 1412.[19]

Section 9(c)(5) expressly forecloses such an approach. Accordingly, the Board's new unit determination rules are unenforceable as a matter of law.

[19] Perhaps more egregiously, the Board's survey of the "history" of collective bargaining in health care institutions was plainly arbitrary. For example, as several commentators noted during the course of the rulemaking proceedings, the Board based its conclusions with respect to prior organizing patterns on an anecdotal analysis of relatively few representation cases. In any event, the Board should have recognized from the outset that its attempt to glean meaningful conclusions from an analysis of the history of collective bargaining in the health care industry was likely to be a wholly futile exercise. Less than thirty percent of the nation's health care employees work under union contract. Becker & Rakich, *Hospital Union Activity, 1974-85*, 9 Health Care Fin. Rev. 59, 65 (1988). Indeed, in many parts of the country, virtually no health care unions exist. *Id.* Thus, while analysis of health care industry "organizational patterns" in New York City and other major cities may be of interest, *see, e.g.*, NPR II, 53 Fed. Reg. at 33,911, it hardly justifies the promulgation of "presumptive" rules of general application.

CONCLUSION

For all of the foregoing reasons, as well as those set forth in the Brief for Petitioner, this Court should reverse the judgment of the Court of Appeals and reinstate the District Court's permanent injunction against the application and enforcement of the Board's health care unit determination rules.

Respectfully submitted,

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